

Dr. Steve de Gruchy's Presentation on the Work of ARHAP

Dr. Steve de Gruchy presented the following information regarding Vesper Society's African Religious Health Assets Program (ARHAP) at a 'Mutirao,' a participatory session, held during the 9th General Assembly of the WCC. The General Assembly took place in Porto Alegre, Brazil, from February 9–24, 2006. Dr. de Gruchy's presentation illuminates the meaning of each word that composes the program's name.

ARHAP is made up of five words, and each one is a helpful way into this introduction.

Health. We start with health because it is the formal context in which we are working, researching and reflecting. This means three things:

1. By health we mean public health. We are not focusing on individual health and its relationship to individual religion. We are focused on a broader sweep of issues to do with health policy and practices which impact upon society as a whole.
2. And as we focus on public health we are consciously locating that within the world of political policy, economic power, and cultural and social forces which shape the way that society is structured and which have a definitive impact upon the health of citizens.
3. We are convinced, for a variety of theological and development reasons, that the health of the people, and particularly the health of women and children, is the most appropriate indicator of the health of a society—rather than the size of the economy or the GDP, or household income.

Africa. ARHAP began with a global focus, and there is no reason why this work does not apply elsewhere. However, at present we are a team of African-lead and African-engaged academics. Our work is located in Africa, and this gives it three important foci:

1. The context of Africa is the context of her children being the victims of a 500-year story of slavery, colonialism, imposed development programmes and structural adjustment. Health is deeply located in this current context of poverty, violence, forced migration, and environmental destruction.
2. At this present time, and specifically in terms of health, the context of Africa is also the context of HIV and AIDS—and this provides the dramatic coalition of issues of politics, economics, environment and public health. It is the constant backdrop of our work.
3. Within this context Africa offers its own deep and powerful insights and resources in terms of health—including its languages which understand health in a broader sense of 'wellbeing,' its traditional religious holistic frameworks, and its deeply committed people who are agents of transformation in the most difficult of circumstances.

Religious. ARHAP locates itself at the intersection of religion and health. We are focused on the way that religion impacts upon health in Africa. For us this means:

1. That we are consciously inter-religious, and not just Christian. We are seeking to draw together and engage with a variety of traditions, respecting them and what they are doing already—rather than seeking a normative or prescriptive model of what is to be done.
2. We are very conscious that in a world where the dominant paradigm for public health policy emerges from the more secular west, that religion is often not taken into account. But we are very conscious that this is a great weakness in Africa where religion is such a powerful factor in people's lives.
3. And we are particularly aware that in Africa, religious groups and institutions provide somewhere between 30% and 70% of all public health facilities. This is something that provides the solid base for our work—but also the challenge, because so little has been done to document and understand this.

Assets. Prominent in the name, ARHAP, is the word 'assets.' What does this mean?

1. It means, first, that we are rooted in an asset-focused approach to transformation, believing that we “cannot build a community on what people do not have.” This is a fundamental attitude that begins with what exists, what is positive, what brings life, what makes people proud.
2. We are interested, then, in what religious groups have and offer in the struggle for health and for life. We are focused on the obvious tangible assets like mission hospitals and church dispensaries, but also on the intangible things that religion offers such as hope, trust, relationships, teaching, networks, prayers, and ethical frameworks.
3. A crucial thing about assets is not just that they exist, but they need to be mapped and understood, and then they need to be aligned with one another because it is in the coherent joining of assets that we are able to build a more healthy world.

Programme. And so that brings us to the fact that this is not just an idea, but is a research programme that is underway in a number of Southern African countries—Zambia, Lesotho, South Africa, Zimbabwe—and that has inspired similar reflection in East Africa, Europe and North America.

1. It is a participatory programme. Everything we have been engaged in takes very seriously the relationship between religion and power. We are seeking to hear from people on the ground, and to do so in such a way that the knowledge and insights that are generated are available to and are owned by local people and leadership.

2. It is a theoretical programme that is seeking to find the language and frameworks to understand this interrelationship between religion and health in Africa. This in a world in which religion is usually understood as an epiphenomenon rather than as a crucial element.
3. It is also an advocacy programme, that it is drawing together knowledge and theory in order to make a difference in the world. ARHAP wants to use this information to impact upon policy formulation for both the religious and the public institutions. We want ultimately to contribute to a more healthy world.

In summary. In a time of HIV and AIDS, of deteriorating public health facilities due to Structural Adjustment Programmes, and of internal political struggles in Africa—we are committed to finding out ways in which religious agencies, people, networks and institutions—what we have called ‘assets’—can make a difference.

1. To do this we need a greater understanding of what religious ‘assets’ already exist, how they work, and how they can be aligned to become more effective.
2. We need also to think of new ways of conceiving health policy in Africa, in frameworks that take this religious contribution seriously.
3. And finally, we need to draw upon the energy that drives religious people and entities forward, to constantly engage this theoretical work in practical action.